PHQ-9 Patient Questionnaire

Nine symptom checklist

Patient Name: _____ Date: _____

Dear Patient,

In an effort to provide the highest standard of care and meet the requirements of your insurance company, we ask that you fill out the form below. This form is used as both a screening tool and a diagnostic tool for depression. Your provider will discuss the form with you during your visit. Thank you for your cooperation and the opportunity to care for you.

1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much.	☐	☐	☐	☐
d. Feeling tired or having little energy.	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

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2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐